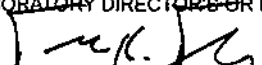


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2017  
FORM APPROVED  
OMB NO. 0938-0391

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>445523</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN</b><br><br>B. WING _____  |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/02/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WELLPARK AT SHANNONDALE</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7512 MIDDLEBROOK PIKE<br/>KNOXVILLE, TN 37909</b>                            |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| K 000  | INITIAL COMMENTS   | K 000  |  |                            |  |
|  | A life safety survey was conducted by the state of Tennessee Department of Health, Division of health licensure and regulation office of health care facilities on 4/2/17. During this life safety survey, Wellpark at Shannondale was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life safety from fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition. |  |  |                            |  |
| K9999  | FINAL OBSERVATIONS   | K9999  |  |                            |  |
|  | During the life safety portion of the survey conducted on 4/2/17, no deficiencies were cited under 42 CFR 483 requirements for long term care.   |  |  |                            |  |

|   |                    |           |
|---|--------------------|-----------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE                             | TITLE              | (X6) DATE |
|  Todd K. Taylor | EVP- Administrator | 4-19-17   |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.